Louisiana Early Hearing Detection and Intervention Program

Audiology Follow-up Services Report (FSR)

Louisiana Department of Health and Hospitals | Office of Public Health
Early Hearing Detection and Intervention (**EHDI**) Program

www.ehdi.dhh.la.gov

Fax within **7 days of appointment** to
FAX# (504) 568-5854

Hearing Aid / Cochlear Implant Report

Child's Last Name (on birth certificate)	Child's First Name (on birth certificate)	Middle Name	Suffix	DOB

Address	City	State	Zip	Phone #	Email

Audiology Facility Name	Audiologist Name	Facility Phone	Facility Fax

Are there any RISK FACTORS for progressive or late onset hearing loss? ***Check all that apply***

☐ **No Risk Factors Identified**

☐ Family History of Permanent Childhood Hearing Loss
☐ Defects of Head/Ears/Neck
☐ Ototoxic Meds >5 days or Combined with Loop Diuretics
☐ Neonatal Intensive Care **Over 5 Days**
☐ Extracorporeal Membrane Oxygenation (ECMO)
☐ Persistent Pulmonary Hypertension of the Newborn (PPHN)
☐ Head Trauma
☐ Neurodegenerative Disorders
☐ In-utero/Congenital Infections (CMV, rubella, etc)
☐ Exchange Transfusion Due to Elevated Bilirubin
☐ Findings/Syndromes Associated with Hearing Loss
Specify Findings_____
☐ Chemotherapy
☐ Postnatal Infections (ex., bacterial meningitis)
☐ Prolonged Mechanical Ventilation
☐ Recurrent or Persistent Otitis Media with Effusion for at Least 3 Months

Date Of Today's Exam / Appointment: _____

Has child been fitted with hearing aid(s)?

☐ Yes LEFT/Date _____ ☐ Yes RIGHT/Date _____

☐ Fitting in Progress ☐ Parent Refusal ☐ Funding Unavailable ☐ Not Recommended

☐ Other _____

Has child been fitted with cochlear implant(s)?

☐ Yes LEFT Date of Surgery _____ Date of Activation _____

☐ Yes RIGHT Date of Surgery _____ Date of Activation _____

Referrals: ***Required to check at least one***

☐ No Referrals Made
☐ Primary Care Physician for Medical Follow-up
☐ ENT/OTO Facility _____City_____
☐ Audiological Evaluation
Facility _____ Date_____
☐ Family-to-Family Support
Organization or Name _____
☐ Hearing Aid Evaluation
Facility Name _____
☐ Genetics Facility Name _____
☐ Ophthalmology Facility Name _____
☐ Early Intervention ☐ Early Steps ☐ Other _____
☐ Other Referrals
List _____

Comments: